# Medical Documentation Tips

The SOAP note (acronym for **subjective, objective, assessment,** and **plan**) is a method of documentation many healthcare providers use to write out notes in a patient's chart. The length and focus of each component of a SOAP note varies depending on the specialty. The SOAP note improves communication between all caring for the patient. It displays the assessment, problems and plans in an organized format. It's very important that everything that needs to be documented in a patient's chart is entered properly, precisely, in the right format, and most importantly, within the legal parameters.

**Subjective Component:**

This component is the patient's chief complaint or CC. This is the "patient quoted" purpose of the office visit. This describes the patient's current condition in a narrative form, which is stated in the patient's own words. The billing provider will also take a history of present illness or HPI. The HPI includes information such as quality location, quality, severity, duration, timing, context, modifying factors, and associated signs and symptoms.

**Objective Component:**

This is the physician's findings which are verified first hand. The objective component includes vital signs, measurements, and findings from physical examinations, including basic systems of cardiac and respiratory, the affected systems, possible involvement of other systems, and pertinent normal findings and abnormalities. Results from laboratory and diagnostic tests already completed can be included in this component.

**Assessment Component:**

This is the physician's summary of the findings. The purpose of the visit should be listed first; it can be associated signs and symptoms if a definitive diagnosis has not been established yet by the provider. Next, list all chronic conditions that are current and that the patient is receiving treatment for in the order of the most severe to least severe. Any past conditions should be listed as "history of" if they are significant to the patient's current condition. Also, include the patient's overall progress since the last visit with the provider in relation to the provider's opinion of the patient's goals.

**Plan Component**

This is what the healthcare provider will do to treat the patient's problems, such as further laboratory and/or radiological workup, referrals, procedures, medications prescribed and any education provided. This component should address each diagnosis and it should also note what was discussed or advised with the patient and further follow-up. Many times the assessment and plan are grouped together. The treatment plan answers the following questions:

- *What is being done for the patient and why?*
- *What is the patient to do or not do and why?*
- *When will the patient return and why?*

### Follow-Up Visits

In general, for follow-up visits, you do not need to list the complete past medical history as the past medical history should be clearly indicated on a master problem list. If the master problem list is not present in the chart, consider making one after the visit and list all history that is relevant to the current visit.

- If there is a separate medication list, update this. If not, the patient's current medications should be documented in the note at least every other visit or whenever there has been an important interval change. Indicate the strength of medication and how often the patient is to take medication. For new prescriptions, indicate how many refills are provided.
- On every note, indicate a specific plan for follow-up ("return to the clinic in two weeks to see Dr. Smith") and the name of the supervising attending ("seen with Dr. Doe").

### Documentation should:

- Be legible so that it doesn't interfere with the ability to code diagnoses.
- Only include standard abbreviations or symbols.
- Show an apparent and legible date of service.
- Clearly state the current treatment and status when there is a "history of" cancer.
- Always support diagnoses codes and include diagnoses descriptions instead of ICD-9-CM (International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes.
- Indicate that the diagnoses are being monitored, evaluated or treated and state whether current or no longer current in "history of" notes.

### Electronic Medical Records (EMRs)

An electronic health record (EHR) – sometimes called an electronic medical record (EMR) – allows healthcare providers to record patient information electronically instead of using paper records. As of February 2014, approximately 6,314 physicians and hospitals have adopted EMR usage in Alabama*.

An EMR saves time and simplifies documentation, but it can be a breeding ground for incorrect billing practices when a patient's information is not verified. A typo in one note can be spread forward indefinitely or be transferred to other records. Make sure you are coding to the highest degree of specificity when using an EMR.

### Helpful Tips:

- Use templates only as prompts for documentation.
- Don't copy block of text or notes from one patient to another.
- Make sure that information is separate and distinct for each patient at each visit.
- The billing provider should perform and documentthe history of the present illness (HPI), the exam, and the medical decision-making process.
- Update the "Current Problems" list at every visit.
- Review and update the medication list with any changes for the patient.
- Make sure that the ICD-9-CM codes are correct.

*Source: http://www.hhs.gov/healthcare/facts/bystate/al.html